Access To Health Care

Health Objectives for the Year 2010: Improve access to comprehensive, high quality health care across a continuum of services.

Health Implications

Access to health care has long been viewed as "a given" in terms of the basic rights and privileges of the American people. However, not all Americans have had the luxury of health insurance, a family physician, or the resources available to them to obtain appropriate and timely medical care. The number of Americans without health care access was small enough in the early part of the twentieth century that it was not viewed as a significant health care issue. Beginning in the 1980s, though an ever-increasing number of Americans found themselves in the very vulnerable position of being uninsured or under-insured. "Access to health care" moved steadily to the forefront of public health issues, the lack of it preying upon our most vulnerable populations: children, pregnant women, and the elderly.

In 1996, it was estimated that 15.6% of the U.S. adult population was uninsured.[1] Similarly, the number of children lacking health care coverage was also skyrocketing, with an estimated 24% of the children in the United States without insurance coverage.[2] The same year in Nebraska at least 8% of the population were without insurance.[3]

Access to a medical "home" has significant health implications. An established relationship between a patient and physician can decrease confusion and the duplication of costly services. Introduction of preventive health screenings and continuity of care is more likely to happen in a setting of doctor-patient familiarity.

Sadly, children are significantly affected by the lack of access to health care. No or little insurance coverage means that children often are not appropriately immunized and may not obtain routine well-child exams. They are most often seen by a health care professional only when they are ill.

Access to health care in a timely and appropriate manner has significant implications for individuals' immediate and long-term health. Delaying treatment for an acute condition often leads to a more complicated and costly resolution. Furthermore, delaying routine care for chronic health ailments can significantly affect the long-term health and vitality of the individual. Inability to participate in routine health screenings (such as a prostate cancer test, mammography, pap smear, or blood pressure monitoring) may significantly delay the detection of serious health conditions, such as cancer, hypertension, and heart disease.[4] Reimbursement for routine preventive health screening has not been a regular

Table 1. Access to Health Care Indicators

	Lancaster Recent	Lancaster Objective 2010	Nebraska Recent	Nebraska Objective 2010	National Recent	National Objective 2010[1]
Percent of the general population 18–64 years of age with health care coverage	90.3[2]	95.0	92.1[3]	--	81.0[4]	100.0
Percent of the racial/ethnic minority population 18–64 years of age with health care coverage	69.8[5]	95.0	--	--	64.9–75.2[6]	100.0
Percent of the population with special health care needs who have access to specialty services	--[7]	95.0	--	--	--	--
Percent of the patient population who are routinely screened about major lifestyle risk factors	--[8]	80.0	--	--	56.0[9]	80.0
Percent of the population who have basic routine screening exams	--[10]	80.0	--	--	--	--
Percent of physicians, physician assistants, nurses, and other clinicians who receive appropriate training to address important health disparities, including disease prevention and health promotion, minority health, women's health, and geriatrics	--[8]	100.0	--	--	--	increase[11]
Percent of children 18 years of age and under who have a specific source of primary care	--[8]	95.0	--	--	91.0[12]	95.0
Percent of adults 18 years and older who have a specific source of ongoing primary care	70.1[13]	95.0	--	--	84.0[1]	95.0
Percent of hospital emergency departments that provide or arrange follow-up for mental health problems, including self-destructive behavior	--[8]	100.0	--	--	--	75.0
Percent of the population with mental health needs who have access to appropriate mental health services	--[8]	95.0	--	--	--	--

practice. In fact, the insurance industry has long practiced a policy emphasizing coverage for illness care over preventive care. Recent studies have suggested that screening is a significant preventive measure for most types of chronic disease. Seeking early care as well as ongoing health monitoring can significantly and positively impact the health of those with chronic disease.[5] Such practices should reduce the number of hospitalizations and emergency room visits caused by chronic health problems. A positive trickle-down effect on quality of health and life does result when health care is ongoing and good health practices are encouraged. These screening guidelines and recommendations can no longer be ignored. Screening questions and education regarding lifestyle risks are commonly overlooked in the time crunch of the office visit. An individual seeking medical help is frequently provided care for "that problem" and only that problem.

Emergency-care access for acute life-threatening situations can significantly impact the outcome of such medical emergencies. Access to emergency care includes the communities' available Emergency Medical Services (EMS) resources, transport travel time, and established, well-equipped hospitals and trauma centers. Furthermore, this accessability needs to be unencumbered by an individual's financial or insurance status and service providers' payment policies.

The issues of health care access are not limited to "the working poor." Insurance coverage, once a common employment benefit, is no longer a given because of dramatic cost increases. Many employers have changed health care coverage and plans, opting for less coverage, higher deductibles, and so forth. The average cost of insurance for a family of four is $3,000–6,000 annually. There are 6,404 business establishments located in Lincoln and Lancaster County. Seventy percent of these businesses have fewer than ten employees.[6] The number of part-time employees and temporary staff making up the work force has grown rapidly and consistently. These individuals are often ineligible for health insurance. As insurance costs have continued to climb, many employees opt to "take a chance," playing a dangerous and costly game of foregoing the purchase of health insurance. Meeting monthly financial obligations including rent, utilities, and food costs takes precedence over the purchase of health insurance coverage. They bank on the fact that they haven't had a health problem recently and anticipate that this status will simply continue, sometimes ignoring the signs and symptoms of chronic ill health.

An unmet insurance deductible, lack of a health plan, or the simple fact that a health crisis will necessitate an unplanned expense act as barriers to care. Lack of transportation, pharmacy services, necessary laboratory services, translation assistance, medical insurance or assistance, referrals to specialists as well as availability of specialists are all components of problems related to health care access.

The lack of a "health benefit" package affects the completion of appropriate treatment. Many people avoid seeking care for an acute illness (such as bronchitis) due to the cost. Often times an individual is able to pay for the office visit to the physician. A problem arises, however, if any additional interventions are needed. A patient who receives a tentative diagnosis of pneumonia may leave a clinic with instructions to obtain a chest x-ray and lab work at one location, proceed to a pharmacy at yet another location, and return to the first clinic, all before the end of the day. Obtaining an x-ray for the definitive diagnosis or purchasing one or more prescriptions is frequently beyond the individual's financial ability. Thus, appropriate implementation of the prescribed plan of care is voided due to

prohibitive costs or the fact that no benefit package exists for the patient. Whether or not these instructions are followed will significantly impact the initial course of treatment, additional care, and perhaps future health problems.

The stigma surrounding mental health continues to this day. Delays in seeking treatment and care for mental-health illnesses are common. As a crisis situation emerges, access to care is found at the emergency room. While appropriate, the crux comes at the time of discharge when follow-up and case management is most needed but often unavailable. Mental-health resource development is needed in those areas that are underserved. Lancaster County has been identified by the federal Health and Human Services agency as having a shortage of mental health care providers.[7]

Millions of Americans suffer from diseases and conditions of the oral cavity that result in needless pain and suffering, and difficulty speaking, chewing, and swallowing; loss of self-esteem; lost wages and productivity through absenteeism from work and school; and in extreme cases, death. Americans for whom the burden of oral disease is greatest often have the most difficulty gaining access to the dental-care system. Access to needed services is critical to eliminate the disparities in oral diseases that are found among members of racial and ethnic minority groups, children from low-income families, and children whose parents have less than a high school education.

Dental health care coverage through a dental insurance program is limited. Reports indicate that access to dental care is an issue of increasing prevalence, not only nationally but on a state and local level as well. Medicaid recipients have found it difficult, if not impossible, to access dental care in Lincoln and Lancaster County.

Not all is bleak however! Access to health care has improved. Actions implemented by our community as a direct result of the Healthy People 2000 objectives related to health care access included the development of a volunteer physician network, the MAC (Medicaid Access to Care) program, Access Medicaid, Kids Connection, and the purchase and implementation of services provided with the Mobile Health Clinic. Nevertheless, barriers to health care access persist. These include access to health services, pharmacy services, radiological exams, and translation and transportation services.

Those at risk for health problems ranging from diabetes to hypertension to cancer in all population subgroups need to be identified. Further, being able to determine if these at-risk populations are currently being screened for disease sets in motion a planned agenda for early diagnosis and intervention through screening in a variety of clinical settings.

Current Status and Trends

The issue of access to health care emerged in the 1980s, becoming a public health issue during the next decade. As a result of this rather recent trend in access to care, the amount of data available has been sparse. A major emphasis needs to be placed on data collection related to access to health care. Standardization of the tracking and reporting of data is vital to the long-term health of the public.

Those most likely to lack access to health care are single heads of households (predominately female) with children under the age of five years, children, single adults under the age

Among adults 18 to 64 years of age:

7%	were unable to see a doctor when needed during the past year, due to cost.
31%	had not visited a doctor for routine checkup within the past year.
30%	did not have a source of ongoing primary care.
10%	did not have health insurance or health care coverage of any kind.

Among those adults without health insurance:

28%	were unable to see a doctor in the past year due to cost, and
47.2%	had not visited a doctor for a routine checkup within the past year.

List 1: Health care access among adults 18 to 64 years of age in Lancaster County, 1999.[1]

of 65, women, and those belonging to an ethnic or minority group including African Americans, Native Americans, Latino/Hispanics, and Asian/Pacific Islanders. The number of female single heads of households with dependent children more than doubled between 1970 and 1990.[8,9]

Changes within our community that have had an impact on health care include the merger of two hospitals, the emergence of independent outpatient surgical centers, the implementation of legislatively mandated Medicaid Managed Care as well as the penetration of managed care to the population at large. The change in management of physician practices from that of an independent nature to ownership by businesses and insurance corporations has evolved. An additional issue is the availability of primary care physicians within the city. There are 481 physicians in the Lincoln community. Three quarters of these are specialists, leaving 25% to provide primary care services to the entire Lincoln and Lancaster County population. Approximately 75% of the primary-care providers will see patients receiving Medicare benefits.[10]

Health Disparities

Disparity in access to care most affects young adults between the ages of 18 and 24.

Disparities in access to care related to ethnic and minority status persist. Twenty-nine percent of the ethnic minority population in Lancaster County is not covered by any kind of health plan, compared to 8.5% of the Caucasian population.[11] Cultural sensitivity affects the health care received by many individuals, particularly in those populations experiencing disparities related to their ethnic or minority status. In a 1993 survey, it was learned that the lack of English-speaking skills prevents approximately 23% of the population from receiving health care services. This is significant to the Lincoln area, as Lincoln is the largest resettlement site in Nebraska for refugees. Lancaster County is among the top three counties in the state with the highest percentage's of population made up of minorities.[1] An issue brought to light by these population changes is the need for competent translation services in the community. This includes not only the need for accurate translation from foreign languages to English but also the return of information to patients from English to their languages. Translators need to know medical terminology to enhance the communication between the medical professional and the patient.

Chronic diseases significantly impact the health status of ethnic and minority populations. While being at significant risk for chronic diseases such as diabetes, coronary heart disease, and various forms of cancer, these populations are least likely to have access to health care or be aware of the need for screenings. Awareness, understanding, identification, and adoption of preventive health screenings for these populations most at

risk is vital. Education of medical professionals from the student to the practitioner in the community is imperative. Only through a concerted effort will we be able to reach those vulnerable populations with early detection, intervention, and treatment, thus improving the health status of millions of Americans, Nebraskans, and Lincolnites. Education on cultural sensitivity to health care providers must continue and be incorporated into all aspects of educational programs. Recruitment of medical-school candidates from a variety of cultures can enhance the medical profession in terms of education, information, and the practice of cultural sensitivity.

Whether one is enhancing the knowledge of professionals on issues related to cultural sensitivity, access to health care, disparities related to health care, or the incorporation of screening mechanisms to detect disease states early on, education is the key. Furthermore, education of consumers is crucial, for in this regard they become active participants in determining their health-care status, choices, and options.

In summary:

- The racial/ethnic minority population is 3.5 times more likely not to be covered by any kind of health plan (29%) than the white population (8.5%).
- In 1996,17.2% of the racial/ethnic minority population reported not accessing care in the prior year because of cost vs. 8.5% of the white population reporting the same.
- Native Americans were most likely to report that they needed to see a doctor but could not see one because of cost (31.6%).
- Of the population surveyed, 23% reported that their lack of English-speaking skills prevented them from receiving health care services.[11]

Public Health Infrastructure

Program Development

Existing service types that have met with success, such as the MAC program, Medicaid Managed Care, and Indigent Care, need to be expanded. New methods of delivering health care need to be considered such as providing care within neighborhoods. To achieve success, it is imperative that consumers be consulted. Identifying key members of the community to provide input, (on the type, location, hours of service delivery, and so forth) and be involved in the process is crucial. Open communication between those lacking access to health care and those trying to eliminate the disparities related to health care access is vital. Assessment of existing data, data collection resources, and future needs must be identified. Establishment of baseline data in many areas is needed. These include:

- the proportion of patients in a medical practice who are routinely screened for major lifestyle risk factors, including diet, tobacco use, alcohol or drug use, exercise, sexual practices, contraception use;
- the number of individuals in the general population who have basic routine screening exams (including blood pressure, blood sugar, mammogram, prostate, and pap smear); and
- the proportion of children 18 years of age and under who have a specific source of primary care.

Educational programs targeting consumers as well as providers on the subjects of cultural sensitivity, screening programs, and health disparities must be expanded. The number of programs directed at educating the general population regarding mental health problems should also be increased.

Recommendations

- Conduct the Minority Behavioral Risk Factor Survey (MBRFS) every three years.
- Train health professionals to address disparities. Medical education facilities will require their staff to receive ongoing education on health disparities, focusing on the areas of disease prevention, health promotion, minority health, women's health, and geriatrics. In addition, a mandatory curriculum focused on cultural competence should be established for all medical students (including, but not limited to, those who will become physicians, physician assistants, nurses, nurse practitioners, lab technicians, physical therapists, occupational therapists, speech therapists, and audiologists). Recruitment of candidates from a variety of cultures can enhance the medical profession in terms of cultural information, education, and sensitivity.
- Collect data about and assess the reasons for late entry to prenatal care.
- Assess the proportion of Lincoln Lancaster County residents who do not have access to a source of primary care. Analyze the findings and recommend strategies to increase access to primary care.
- Collect data to identify neighborhood health care needs and income level.
- Develop, promote, and increase the use of neighborhood-based clinics for well-child care, adolescent care, primary care, mental health services, prenatal care, parent education, prevention education, and dental care.
- Convene a task force to study dental-care access.
- Conduct a mental health survey of all youth and adults.
- Increase the number of competent bilingual staff in health care settings.
- Publish and distribute newsletters related to health issues in different languages.
- Develop public education spots in other languages for cable-access television (and radio).
- Develop a Quality Management Monitoring Program for outpatient surgical centers, wound centers, dialysis centers, and other outpatient medical care facilities for the purpose of assuring quality of services to all.
- Develop a community plan to address language translation resources for improving access to health care.
- Develop a community transportation advisory committee to study the impact of transportation on access to care.

Notes

Related discussion or indicators are located in the chapters on *Maternal and Child Health*, *Oral Health*, *Nutrition and Physical Activity*, and *Immunization and Communicable Disease*.

Table 1

-- Currently no data source.

1. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998.
2. Lincoln–Lancaster County Health Dept., Behavioral Risk Factor Survey, 1999.
3. Nebraska Health and Human Services, Nebraska Behavioral Risk Factor Surveillance System Report, 1995–96.
4. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998. 1996 data from National Medical Expenditure Panel Survey.
5. Lincoln–Lancaster County Health Dept., Minority Behavioral Risk Factor Survey, 1994.
6. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998. 1996 data for African-American (75.2%) and Hispanic (64.9%) populations.
7. Currently no data source. Populations with "special health care needs" should include children, pregnant women, the geriatric population, and persons with disabilities.
8. Currently no data source. Could be measured through a community survey tool.
9. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998. 1994 data from National Health Interview Survey.
10. Can probably be calculated from BRFS data. "Basic screening exams" should include regular screening exams for blood pressure, blood sugar, mammogram, prostate exam, and pap smear test.
11. National developmental objective is to increase medical personnel training to address health disparities; currently no data source.
12. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998. 1995 data from National Health Interview Survey.
13. Behavioral Risk Factor Survey data, 1999. Emergency rooms are not included as an appropriate source of primary care.

List 1

1. Behavioral Risk Factor Survey data, 1999.

Narrative sources

1. Nebraska Health Information Project 1997 Databook.
2. U.S. Bureau of the Census, March 1998, 1997, 1996 current population survey.
3. Nebraska Health and Human Services System, Behavioral Risk Factor Survey, 1995–96.
4. C. Hafner-Eaton, "Physician utilization disparities between the uninsured and insured," *JAMA* 269, 1993, pp. 787–92.
5. Nebraska Diabetes State Plan 1997–2000, pp. 9–11.
6. Nebraska Department of Economic Development, 1996 data.
7. Nebraska Health Data Report.
8. Special Public Health Report, an Update, Women's Health in Lancaster County.
9. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People Draft 2010 Objectives*, September 1998. MEPS data.
10. Lancaster County Medical Society, September 1999.
11. Lincoln–Lancaster County Health Department, Minority Health Survey in Lincoln, Nebraska, 1994.